THE
MEDICAL AND SURGICAL REPORTER.

No. 1043.] PHILADELPHIA, FEB. 24, 1877. [VOL. XXXVI.—No. 8.

ORIGINAL DEPARTMENT.

COMMUNICATIONS.

A CLINICAL STUDY OF THE MORE FREQUENTLY OCCURRING FORMS OF CONJUNCTIVAL DISEASE.

BY S. D. RISLEY, M. D.,

Chief of the Dispensary for Eye Diseases, at the Hospital of the University of Pennsylvania.

(Read before the Philadelphia County Medical Society, December 27, 1876.)

(*Concluded from No.* 1042.)

In the second group, the *phlyctenular*, are included only those cases of conjunctivitis presenting the strumous facies, and occurring, for the most part, among the children of the poor. These cases present an entirely characteristic group of symptoms, both local and general, which separates them widely from the catarrhs.

A careful study of the local symptoms in a well developed typical case will reveal an agonizing dread of light, which causes the child to bury its head in the pillows or its mother's lap, to exclude every possible ray of light. The face being forcibly exposed to light, there is seen the most vigorous spasmodic closure of the eyelids. So strongly do the muscles contract that the brow is corrugated and the lineaments of the entire face changed. There is eczema of the cheeks, from the scalding tears and the constant burying of the face in the bed clothes wetted by the tears. The upper lip and the nostrils are excoriated and thickened, from the profuse discharge of tears and mucus through the nasal passages.

The condition of the conjunctiva is quite characteristic. There is fine capillary congestion, but the conjunctiva is *transparent*, even though the case may have been of many months' duration. In this it differs from the catarrhal conjunctivitis, in which the membrane becomes opaque, often, in twenty-four hours.

The entire surface of the conjunctiva, both the tarsal and bulbar portions, will be found more or less profusely studded with minute elevations; and along the limbus of the cornea, sometimes entirely encircling it, is seen a chain of larger elevations, which appear like minute blisters, and fasciculi of enlarged blood vessels are seen approaching them from the region of the retro-tarsal fold; or there may be one or more ulcers on the cornea itself.

The intense photophobia, the transparent conjunctiva, studded with phlyctenulæ, the flow of tears, the spasmodic closure of the lids, and the cachexia, form a group of symptoms differing very widely from those delineated as characterizing the catarrhs. Differing as radically as they do in their essential characters, the treatment demanded is scarcely less at variance with that pointed out in the former.

In phlyctenular ophthalmia, astringents and caustics do harm. I have seen them grow worse, even under the use of a mild collyrium of alum. The most important element in the treatment is to improve the general condition of the child. The eyes will not get well, and remain so, until this is done. I have, repeatedly, for many weeks together, treated faithfully these little sufferers, and without any improvement in the condition of the eyes, until there was an obvious improvement in the general health. I am convinced that the condition of the

conjunctiva is not altogether peculiar to it, but that were the other mucous membranes open to inspection we should find similar pathological conditions, modified possibly by local differences in structure; so far as the mucous membrane covering that part of the soft palate exposed readily to view is concerned, this is certainly true. The same condition in the alimentary mucous membrane is doubtless indicated by the precarious appetite and deranged bowels. Once the appetite improves, the bowels get well, and the emaciated limbs grow rotund, the child will resume its play in a moderately lighted room. The spasm of the orbicularis gives way, and the eye rapidly gets quiet and comfortable. There can be no greater mistake than to shut up a case of phlyctenular conjunctivitis in the house and in a dark room. The eyes should be shaded, but not tied up, and the patient required to spend many hours daily in the open air, in the park or country, if possible. I have often felt that more of the cure, in these cases, was due to the daily visit to the dispensary, than to my applications while there. The time usually required at the service, and the long ride to and from the hospital, consumes from two to four hours daily, which is quite a respite from the bad air of the court and the common living room, in which, too often, the child was born, and thus far reared.

These children are regarded as scrofulous, by the parents and friends, and there is a popular notion that meat should be avoided in such cases; so that this important aliment is usually interdicted. I am in the habit of advising fresh meat, milk, eggs, etc.—and all the child will take of them. I have thought the iodides were important to these children, and prefer, before everything else, the iodide of iron, which, after a time, may be changed for potassium iodide, in small doses. The local treatment is very simple. As long as the photophobia and orbicular spasm continue, I have confined myself to the simple instillation of sulphate of atropia solution at the daily visit to the dispensary, the parents to use the same, but a weaker, solution, at home. As soon as the irritation subsides, a careful insufflation of iodoform has seemed to hasten the cure, a weak solution of corrosive sublimate, gr. $\frac{1}{8}$–$\frac{1}{12}$ to the fl. ℥j of water, being substituted for the atropia, at home. An ointment of the yellow oxide of mercury and atropia, āā grs. j, to ℥j of lard or other excipient, has, in some cases, appeared to be of service when other things had apparently failed.

As long as the disease is confined to the conjunctiva, it is comparatively an innocent affair, so far as danger to vision is concerned; but it is too frequently associated with phlyctenulæ on the cornea, which result in small ulcers, which may even perforate the cornea, and thus lead to more or less disastrous results, from the entangling of the iris in the wound, and from corneal specks, which, if central, may seriously mar the sharpness of vision, by shutting out the central rays of light from the pupil. I have seen very many unfortunate cases of this character.

There are many cases of conjunctival disease which do not accord with the history of either of the forms already delineated. They have not the same dread of light, nor is there the so-called strumous facies of phlyctenular disease. On the contrary, the disease may occur in children or adults, situated under the most inviting and favorable surroundings. When occurring in children, it is usually after the fifth or sixth year, while in those cases already described it occurs, for the most part, before the fifth year of age. I have learned to regard these as belonging to quite a different category, and have placed them in a third *group*, and for want of a better name, have designated them as *symptomatic*. To it belong the very many cases of mild conjunctival trouble which worry patient and doctor by their persistency. However intelligently he may prescribe, they either get no better or only temporary improvement follows.

They are characterized by hyperæmia of the tarsal conjunctiva, and careful inspection reveals through it the congested tortuous meibomian glands; the conjunctival surface is studded with numerous minute elevations, like small, whitish sand grains, and possibly somewhat larger bodies scattered very sparingly, if at all, over the tarsal portion of the conjunctiva, but more numerous in the retro-tarsal folds. Often the tarsal border will be thickened and scaly. The patient complains of weak eyes, by which he means that he finds difficulty in using them for near work. If obliged to do so, the scratching of the lids, burning sensation in the eyes, or possibly eyeache, or a peri-orbital neuralgia, are the penalty he must pay. The symptoms are aggravated in seasons of depressed health, or after unusually protracted

use of his eyes. They may even run on into serious and persistent inflammatory trouble. The hyperæmia which at first existed passes into proliferation and the conjunctiva becomes thickened and opaque. The long standing inflammation passes, by continuity of tissue, into the lachrymal passages, and obstruction to the flow of tears ensues, which in turn aggravates the conjunctival disease. The now thickened and granular membrane can no longer function properly, and the cornea soon suffers in consequence. In a word, all the features of chronic granular ophthalmia are presented.

Under the usual treatment adopted in these cases, if entire rest be insisted upon, these cases get well, after a time; but the hope of a permanent cure is blighted as soon as they resume their work. The group of cases presenting this history will usually be found to have some local cause for their protracted or recurring trouble, and I am convinced the defects of refraction and muscular insufficiency are responsible for it. The constant undue strain upon the ciliary muscle, which is the price that must be paid for distinct vision in certain of these defects, brings about a general ocular congestion, which very frequently passes into pathological conditions which no treatment, however skillfully conducted, will permanently relieve, so long as the ever active agent in its production is present. Very many times I have seen these stubborn cases go on to rapid and permanent recovery while wearing a glass correcting the anomaly of refraction, which had before baffled all my resources. The treatment is, first, to get rid of the inflammatory trouble, and before work is resumed correct any existing defect in the refraction by suitable glasses, and to obviate the insufficiency of the rectus muscles by operation or by prismatic glasses.

That this distinction is not a refinement of nosology, my case-book bears me abundant witness, and I have, therefore, placed them in a separate category, hoping thus to more positively direct attention to them. I beg your attention to a brief analysis of over six hundred cases of conjunctivitis upon which these remarks have been based. It will be evident from it that the true catarrhal and strumous ophthalmia occur, for the most part, among the poor; that a very large percentage of cases of conjunctival disease, simulating more or less closely the one or the other, but associated with refraction and muscular anomalies, occur under very different hygienic conditions, and undoubtedly depend upon the defects in the eye itself. In my private practice, conjunctival disease occurred in seventeen per cent. of the whole number of cases treated; of these, 19 per cent. were catarrhal, 27.4 per cent. were strumous, and 53.6 per cent. were symptomatic.

At the dispensary service, on the other hand, 27.65 per cent. of the whole number of cases treated were of conjunctival disease. Of these, 35.6 per cent. were catarrhal; 41.4 per cent. were phlyctenular, and 23 per cent. were symptomatic.

Group.	Percentage to whole number of cases treated.		Percentage to number of conjunctival disease.	
	Dispensary.	*Private.*	*Dispensary.*	*Private.*
Conjunctival Disease	27.65	17	.....	.....
Catarrhal	.....	.....	35.6	19
Phlyctenular	.....	.....	41.4	27.4
Symptomatic	.....	.....	23	53.6

In the symptomatic group are included only the cases which came complaining of the conjunctival trouble as an important, and, in many instances, the only symptom, but in which there existed insufficiency of the recti muscles, or a considerable degree of anomaly of refraction, which was, in each case, regarded as an important agency in the cause of the disease, and treated by operation, or prisms, to relieve the muscular insufficiency, or, in the latter case, by the careful measurement, and correction by glasses, of the defect of refraction.

The persons usually applying at our dispensary services are exposed more to the influences which produce the catarrhal and strumous forms of disease, while they have much less demand for continued, accurate work at a near point, as in reading or writing. The opposite condition obtains among the more thrifty and well-to-do classes of society; their pursuits calling for near and accurate use of the eyes, and a corresponding strain upon the muscles of convergence and accommodation. When, through some defect, this strain is unduly increased, it very frequently reveals itself in the group of conjunctival diseases which I have designated as symptomatic, and which so frequently baffle all treatment until the existing defect is obviated by proper means

—Dr. Ralph M. Townsend, formerly on the staff of the Reporter, is wintering in California.

FLUID WEIGHTS IN PRESCRIPTIONS.

BY ALFRED B. TAYLOR,

Of Philadelphia.

The National Convention of 1870, for revising the United States Pharmacopœia, by its sixth resolution, decided "That measures of capacity be abandoned in the pharmacopœia, and that the quantities in all formulas be expressed both in weights and in parts by weight." Although, owing to the great labor required in making the necessary reductions, and to the still greater difficulty and responsibility involved in selecting the most judicious readjustments of relative quantities, the Executive Committee of the Convention failed to give effect to this resolution, there seems to be little doubt that the tendency of modern professional thought lies strongly in the direction of the resolution, and that it will probably be carried into execution by the next decennial Convention of 1880. It is not too soon, therefore, to begin the work of preparation for this considerable revolution.

In the event of such a radical metric substitution, it is not to be expected that the existing quantities (by fluid measure) will be preserved, and merely translated into their equivalent terms of weight. This would only increase the complexity of therapeutic practice without giving any adequate advantage, since the ingredients of compounds as well as compounds themselves would be generally expressed in indeterminate or unmanageable fractions of the *grain* or of the *gramme*. It is obvious, therefore, that in accordance with the officinal formulas, the physician should learn to prescribe, and the druggist to dispense, his medicines in simple and integral units of weight.

It is not irrelevant here to note, that whether the ultimate system of conversion comprise the substitution of weights for volumes, or of one order of weights for another order, no necessity exists (excepting for purposes of rigid comparison) for preserving exact translations or precise equivalents of proportion. It is quite sufficient that good approximations to established values be attained. Physiologically and therapeutically there can be no very accurate determination of the mathematical value of an average effective dose of any agent; and no reason can be assigned for regarding one grain of opium (for example) as a medium sedative dose, rather than $\frac{11}{12}$ of a grain, except its convenience, by our existing notation. This consideration is calculated to prevent a large amount of superfluous labor and anxiety likely to be bestowed by some on very minute determinations of metrical equivalents.

In considering any attempt at the introduction of the proposed change of system in dispensing medicines, two formidable practical difficulties at once suggest themselves. First, that from the considerable range of specific gravity in the articles of the materia medica, ordinary prescriptions would fall into an extreme irregularity of disposition in relation to quantity; and secondly, that after such prescriptions were compounded and dispensed, they would present an extreme inconvenience and uncertainty in the administration of the proper dose to the patient. To meet and surmount these two difficulties, is the object of this communication.

In the first place, with regard to the method of prescribing. By means of carefully prepared tables (which will, undoubtedly, be universally current, and cheaply accessible), the physician should accustom himself to think of, and employ, the nearest simple unit of weight for a single dose of each of the active agents employed. These units being severally noted, should be written down in the recipe, preferably in multiples of eight (8, 16, 24, 32, 40, 48, etc.), as this will be found much more convenient to the dispenser in distribution (whether of pills, powders, or mixtures), than would be multiples of ten. The number of doses being thus selected, they should be incorporated (in the case of fluid mixtures) with a sufficient quantity of the adjuvant, or the inert vehicle, to make the whole mixture amount to a determinate volume, dependent on the consideration and solution of the remaining difficulty.

In the second place, with regard to the method of administration. As it would be manifestly hopeless to expect that patients or their attendants would have either the means or the skill to weigh out each particular dose of a fluid medicine at the time of its use, the familiar spoon, so universally "resorted to for dividing the medicines at the bedside," must continue, as pointed out by Professor Maisch in this journal,* to "be employed in the sick-room." Were the whole mixture made a determinate weight, therefore, even though the precise value of an

* "The Use of Metrical Weights in Prescriptions," MED. AND SURG. REPORTER, Sept. 9, 1876, vol. XXXV, p. 202.

ordinary teaspoonful (or of a fluid-drachm) could be estimated, the dose might naturally amount to three-fifths, or to five-sevenths, or some other equally impracticable fraction of such spoonful. The obvious conclusion from all which is, that while medicines should be prescribed by the weights of their doses, and carefully compounded by the weights of their doses, the physician should provide that the finished mixture shall, for the purpose of dispensation and administration, measure a determinate fluid volume, comprising by multiples of eight the inevitable fluid-drachm, or popular teaspoonful.

This comparatively simple compromise appears to present the only practicable solution of the problem in hand. Whatever the standards employed in the preparation of the liquid (from the simplest to the most composite), the dose, as actually administered and taken, must constantly be some familiar measure of volume; and it will, therefore, become the duty of the physician (and of his executive minister, the pharmacist) to consider and accept this stubborn fact. While, for example, the dose of the standard "tinct. opii" would be registered and prepared in grains (or their equivalents), it must ever continue to be taken in drops, the popular equivalent of minims. So the physician wishing to administer, say the sixteenth of a grain of strychnia, a grain of quinia, together with a half-drachm, by weight, of the compound tincture of gentian, in a little syrup, would frame his prescription as follows:—

℞.	Strychniæ sulph.,	gr.1.
	Quiniæ sulph.,	gr.16.
	Tinct. gent. comp.,	℥1.
	Syrup. zingib., a sufficient quantity.	M.

To make in all two fluid ounces.

This would give sixteen fluid-drachms (or teaspoonfuls), each containing the desired weight of the several agents indicated: and this is but carrying out the plan in very general use.

Should our own familiar weights be abandoned and superseded by the adoption of the metrical gramme, as advocated by Professor Maisch, in his article already alluded to (and as seems to be the tendency of "manifest destiny"), then a further suggestion occurs, as probably best adapted to bring such unit into convenient relation to the popular need and usage.

First, by the employment of "grammes" and "centigrammes" only, for all medicinal weights, the notation would be at once familiarized by its precise analogy with that of our established currency, which is always expressed in similar terms of "dollars" and "cents." Thus, 2½ grammes should never be so written, but always grammes 2.50 (equivalent to 250 centigrammes). "Decigrammes" should be an unknown quantity. "Milligrammes," the analogue of our monetary "mills," would be written in the same manner, and would probably be as rarely used.

As the notation $ 0.00,7 expresses 7 mills, so (using G as the abbreviation of gramme) the corresponding notation, G 0.00,7, would express 7 milligrammes; preferably, 7 tenths of a centigramme. The expression, G 0.00,1 (1 tenth of a centigramme), is practically equivalent to 1 sixty-fifth of a grain; while—

1 gr. is practically equivalent to	G 0.06,5	(6½ cg.)
2 grs. "	" G 0.13	(13 cg.)
G 0.01 (1 centigramme)	" gr.⅙—	
G 0.10 (10 centigrammes)	" gr.1½+	
G 1.00 (1 gramme)	" 15⅖—	
G 4.00 (4 grammes),	" ʒ1 (+1¾ grs.)	

Eight times the latter weight (G 4.), or G 32, would be in excess of 1 ounce only 13⅘ grains; ordinarily a wholly insignificant difference.

Secondly. By the employment of a related metric unit of capacity, it will be easy to attain the "objective point"—a convenient administration of the dose. The gramme of distilled water is, by the metric system, called a "millilitre," and represents very nearly 16¼ minims; differing, therefore, but slightly from the fourth part of a fluid drachm, or 15 minims. This metric unit of capacity might very appropriately and suggestively be designated a "fluigram," being required only for medicinal uses, and being directly related to the assumed standard weight of pharmacy. Four of these "fluigrams" represent a capacity of 64.9 minims, or not quite 5 minims more than our fluid drachm; which, translated into the "vulgate," signifies 5 drops over the average teaspoonful. It is needless to say that common teaspoons vary much more than this in their capacity, and very much more in their usual condition of "fullness." If, therefore, the physician were to frame his finished dose of a mixture on the basis of this measure, there would be practically no inconvenience or inaccuracy in directing it to be administered in the usual way.

In order, however, to remedy the very irregularity which now exists from the uncertain capacity of the common teaspoon, it would be very desirable that a medicinal spoon of uniform and standard capacity should be authoritatively and generally adopted. Were the "Metric" weights established, spoons accurately made to hold exactly four fluigrams might very properly be called "metri-spoons," and would prove a great convenience both to the physician and to his patient. They should be manufactured both in glass and metal; and for facility of movement without spilling, as well as for greater accuracy in filling, the bowls of such medicinal spoons should be deeper and more spheroidal than those in common use.

For larger doses than the teaspoonful but a single additional measure would be required to complete the domestic equipment, a substitute for the very uncertain two-ounce "wineglass." A glass vessel somewhat of the form of the apothecaries' two-ounce graduate, accurately marked to show the capacity of 17.314 fluid drachms, might be called a "metri-glass." Its capacity would be in excess of the double fluid ounce by f.$\mathfrak{Z}1\frac{1}{3}$; and if graduated to eighths, its lowest division would represent the double "metri-spoon." This useful vessel would, therefore, comprise the equivalents of the double teaspoon or dessertspoon, the tablespoon, the double tablespoon, and the wineglass.

These two terms, "metri-spoon," and "metri-glass," would, from the nature of the case, soon come to signify the abstract measure, as well as the concrete implement; rendering the use of the suffix "ful" superfluous. The direction, "a metri-spoon three times a day," would thus naturally supersede the expression, "a metri-spoonful." Were the gramme and centigramme authoritatively adopted, the employment of these weights (after having been translated by suitable tables) would be found to be much less troublesome than might be supposed. With a little practice, the use would, of course, soon become as convenient as that of our own weights at present.

The following illustrations of "metric" prescriptions may here be given, to show their comparative facility.

℞ Potassii nitrat., G. 5.20 (= gr. 80¼)
Pulv. scillæ, G. 1.00 (= gr. 15½)
Ft. pulv. in chart. 8 divid.
Sig.—One powder to be taken two or three times a day.

Each powder will, therefore, contain of the nitrate of potassium, 10 grains ($+\frac{1}{40}$ grain) and of the squill 2 grains ($-\frac{1}{14}$ grain).

The officinal "Compound Cathartic Pill" (U. S. P.) contains 1½ grains of the compound extract of colocynth, 1 grain of powdered jalap, 1 grain of the mild chloride of mercury, and ¼ grain of powdered gamboge. Supposing that it were desired to make forty-eight of these pills by "metric weight, naturally forty-eight times these respective quantities translated into the nearest whole number of grammes and centigrammes would be the weights of the ingredients employed for the mass.

℞ Ext. coloc. comp., G. 4.00 (= gr. 61¾)
Extr. jalapæ, G. 3 00 (= gr. $46\frac{3}{10}$)
Hyd. chlor. mitis, G. 3.00 (= gr. $46\frac{3}{10}$)
Gambogiæ, G. 0.80 (= gr. 12½) M.
Ft. pill. 48.

Of the last named article, the quantity might be written 80 cg. Each pill will contain of the first ingredient $\frac{1}{21}$ of a grain less than the officinal quantity; of the second and third ingredients $\frac{1}{23}$ of a grain less than the officinal quantity; and of the last ingredient $\frac{1}{130}$ of a grain more than the officinal quantity. Were there any assignable object in preserving the precise quantities given in the Pharmacopœia, to the nearest grain for the whole mass, this could easily be effected by taking of the first ingredient G. 4.15, of the second and third ingredients G. 3.11, and of the last ingredient 78 centigrammes. While, however, there would probably be no appreciable difference of action between these two proportions, the former recipe is evidently the neater formula.

As an example of a fluid medicine or mixture, the formula of the well-known "Griffith's Myrrh Mixture" (*Mistura Ferri Composita* of the U. S. P.) may be offered:—

℞ Myrrhæ G 4.00 (=gr. 61.74) an excess of 1¾ gr.
Sacchari G 4.00 (=gr. 61.74) an excess of 1¾ gr.
Potass. carb. G 1.75 (=gr. 27.) an excess of 2 grs.
Ferri sulph. G 1.40 (=gr. 21.6) an excess of $1\frac{6}{10}$ gr.
Spt. lavand. G 14.50 (=gr. 223.8) a deficit of 1½ gr.
Aquæ rosæ a sufficient quantity to make in all 240 "fluigrams" (or 60 "metri-spoons").*

These examples are sufficient to indicate the real simplicity of the method for expressing not only fluid quantities by weight, but also those weights in the unfamiliar "metric" system.

*It may be noted that the quantity, 60 "metri-spoons (240 "fluigrams") is almost exactly equal to 8 fluid ounces, being equal to 64.9 fluid drachms.

To recapitulate—the purpose attempted in this paper has been to point out, first, that fluid medicines may be as easily prescribed and dispensed by weights as by volumes, after a proper tabulation of effective and maximum doses of the entire materia medica in units of weight; secondly, that mixtures so prepared may be administered with perfect facility by familiar measures of volume; thirdly, that in the event of the officinal adoption of the "metric" gramme, its notation can be made exceedingly simple and convenient; fourthly, that in this case, while no serious disadvantage would result from the retention of the familiar fluid-drachm, or teaspoonful, yet, for the sake of greater precision and neatness, the "fluigram" (the French millilitre) should be the popular unit of volume for the actual administration of fluid medicines; and lastly, that, for the sake of certainty and uniformity, the "teaspoon should be replaced by a standard medicinal spoon, holding just four "fluigrams," and the ordinary, but variable, "wine-glass" should, in like manner, be superseded by a "metri-glass" having the capacity of sixteen such standard medicinal spoons.

These suggested reforms would none of them be found to be very difficult of introduction, and they would result in the advantage to the profession of a great permanent convenience, facility, and trustworthiness in the employment and exhibition of therapeutic agents.

LIMIT OF THE SURGEON'S RESPONSIBILITY.

BY FRANCIS H. MILLIGAN, M. D.,
Of Wabashaw, Minnesota.

Read before the State Medical Society, February 1st, 1877.

The responsibility of the medical man, more particularly the surgeon, has been, and is now, the source of a great deal of medico-legal discussion.

In this country and in England the great weight of the authorities is, that no distinction exists between regular and irregular physicians and surgeons.*

1. If the defendant acted honestly, and used his best skill to cure, and it does not appear that he thrust himself in the place of a competent person, it makes no difference whether he was at the time a regular physician and surgeon or not.

2. To constitute guilt, gross ignorance or negligence must be proved.

3. A defendant, who, with competent knowledge, makes a mistake in a remedy, is not answerable; but it is otherwise when a violent remedy, shown to have occasioned death, is administered by a person grossly ignorant, but with average capacity, in which case malice is presumed, in the same way that it is presumed when a man, *compos mentis*, lets loose a mad bull into a thoroughfare, or casts down a log of wood on a crowd.

4. When competent medical aid can be had, the application of violent remedies by an ignorant person, though with the best motives, involves him in a criminal responsibility.

5. Express malice, or an intent to commit a personal or social wrong, make the practitioner criminally responsible in all cases of mischief.

There is a growing opinion in the community, that the surgeon should be held responsible for all the failures that occur in his practice. If a deformity results from a fracture, or an operation proves a failure, the surgeon is not only blamed by the community at large, but, unfortunately, his own brethren are too often ready to lend their aid to the general clamor. Therefore, at least two-thirds of all the difficulties resulting from malpractice suits are the result of words spoken in an unguarded moment by some rival practitioner. This is not the case with the practitioner of medicine, for however badly a case of disease may have been treated, few, if any, physicians are blamed for the results. On the other hand, let a surgeon cure a fracture with deformity, or reduce a dislocation, or fail to cure a diseased joint, and he is too often blamed for the results, over which he had really no more control than the physician over the disease treated by him.

Years ago, in civil practice, I attended a case of gunshot wound of the left lung, penetrating the cavity of the thorax, the ball being extracted by me from near the spinal column, on a line corresponding to the lower border of the left scapula. This case remained under my care for about three years, the wound of entrance never healing. The patient, being desirous of having the opinion of some more experienced surgeon, went to St. Louis, and consulted the late Professor Charles A. Pope. After having examined the case thoroughly, Dr. Pope re-

* See Wharton & Stillé, Ed. 1880, Sec. 1253.

marked, in that kind and gentle manner which was so peculiar to him, "My man, it is too late; I can do nothing for you." Now, this remark caused my patient to return to his home with the idea that I was responsible for his not being cured. I immediately wrote to Dr. Pope, and received an answer, in due course of time, expressing the following language: "All was done by you, in the case, that could have been done by any man (good or bad surgeon). The result would probably have been fatal under any treatment, and you, my friend, are not to blame, or responsible, for the result. The remarks uttered by me to Mr. W. were intended to mean far different from what he construed them, and is another instance to show that we cannot be too guarded in our language to the patients of others."

Public opinion, however, will very often err in regard to the success of a surgeon. Operations of the most simple nature get into the hands of the reporters of the secular press, and honor is too often bestowed where none should be given.

Again, our successes are heralded far and near, and our failures too often hidden from the public gaze and curiosity. Surgeons, as a class, are subject to all the frailties of other men, and we do not like to hear of our failures, but, in reality, enjoy the public esteem too often dishonestly obtained at the expense of our professional honor. It does rest upon us all to consider these things very carefully.* We are all the more bound to consider them honestly, and, if need be, with self-reproach, because these calamities are not such as the public can judge of; they are not instances of those negligences and carelessnesses which can be punished legally and openly.

All men are liable to error. Men of the largest experience, and of undoubted ability, often make very serious mistakes; for this reason it has always been my custom to request the opinion of my professional brethren, and thus divide the responsibility in case of failure.

We cannot pass over the remarks of one of England's most successful surgeons.† I venture to say that there is no surgeon in large practice, no surgeon to a large hospital, who has not once or more, in the course of his life, shortened patient's lives when he was making attempts either to prolong them or make them happier. And this, you will observe, is not merely the case with capital operations. When a patient submits to a large operation, it is always for the remedy of something that will render his life either very miserable or very short; and to escape so great distress, it is quite fair that a man should run great risk of his life.

Calamities in surgery may come of things which nothing far short of omniscience could have detected beforehand.

Tetanus may ensue, after a minor operation. We have no power to avert that, or even, in the smallest degree, to apprehend its approach. These, and other causes of the kind, and still more, the negligence of patients, would diminish, by a considerable number, the list of calamities for which we seem to be blameworthy.

There is a limit to the surgeon's responsibility. Notwithstanding the greatest care and attention deformities will sometimes occur, and a surgeon who has been in active business for a period of years, if honest, will admit that some of his cases resulted badly. We know that more than two-thirds of the malpractice cases are the result of fractures, and the deformity therefrom. If under the best care these deformities result, as a natural consequence, under the care of our country surgeons, who are but poorly provided with surgical appliances, they are to be expected oftener. In hospital practice or in our large cities better cures are made in fractures, not because the attending surgeon possesses more ability than his rural neighbor, but because he has greater access to his patient, seeing him daily, or if necessary, twice daily. This would be impossible in our rural districts, and hence we must all admit that the country surgeon meets with more serious results than the surgeons in our large cities.

An American surgeon* who at home and abroad justly stands in the front ranks of his profession in the "green room," has been in the habit of remarking that a surgeon in Wisconsin should know as much as one in Philadelphia, and insists that no man should take the responsibility of treating a fracture that he could not see daily.

The common law expects a surgeon to see his cases as often as the circumstances will admit. Neglect is a hard subject to go before a jury. It is right that it should be so. We will go as far as any man to punish neglect and ignorance

* Paget's "Clinical Lectures," p. 51.

† Paget's "Clinical Lectures and Essays," p. 53.

* Professor S. D. Gross.

on the part of a surgeon, but this general and vulgar clamor about a surgeon's being rich, and ought to be made to pay for the shortening of the limb of some pauper case which has fallen into the hands of some ambitious attorney, is unworthy the jurisprudence of the age, and ought to be done away with.

The habit pursued by the eminent Dr. E. B. Wilcott, of Milwaukee, should be imitated by us all. When he is consulted by parties wishing an opinion to establish a case of malpractice, he examines the case thoroughly, takes notes, and invariably remarks to the parties, "what I know of this case, sir, I will tell to the court and jury." How much better is this remark than the one so often given; "a bad leg sir, *very bad*." "I have no such arm as this in my practice."

At a recent trial, in Red Wing, Dr. Hewitt was sued for malpractice, because he amputated a hand at the wrist-joint, on a minor pauper, in the month of December, 1868. This was a case of lacerated gunshot wound of the hand, opening the wrist-joint, tearing arteries and nerves; and because the little and ring-fingers could be flexed, this was considered sufficient to ground a suit for malpractice. The plaintiff actually thought that he had been maimed, and had, for seven years, brooded over his supposed wrong; the imprudent advice of some medical men, from the misstatements in the case of the plaintiff, was the cause of the suit. If a little patience had been shown, and the golden rule applied, this case would not have occurred. You all know how it resulted. And let me here take occasion to state that the attorney for the plaintiff deserves the respect of every regular surgeon and physician in the State, for the just and honorable manner in which he apologized to Dr. Hewitt and the profession at large for the unintentional wrong he had done them.

As a protection against suits for malpractice, your committee would earnestly recommend that the Legislature of the State pass a law of the same nature as the one recently passed in New York.*

—Among recent experiments made in Bavaria, relating to the preservation of animal food, the military authorities have derived great satisfaction from those in the desiccation of eggs. These can be preserved, in a dried state, retaining all their nutritive qualities, for transportation.

*MEDICAL AND SURGICAL REPORTER, Vol. xxxiii, p. 256.

HOSPITAL REPORTS.

PENNSYLVANIA HOSPITAL.

CLINIC OF PROF. J. M. DA COSTA, Dec. 22d, 1876.

REPORTED BY FRANK WOODBURY, M. D.

Case of Congestion of Brain, Complicating Brain Tumor—Convulsions, followed by Aphasia and Hemiplegia—Recovery.

GENTLEMEN:—About three weeks ago the patient just brought before you was admitted to the hospital suffering from acute catarrhal jaundice, following exposure to wet and cold. He also had an old history of syphilis, as we find recorded in the notes made upon his admission into the ward. His name is Frank P——; he is 42 years of age, and his occupation is that of a fireman. He acknowledges that when 19 years old he contracted a chancre, but he does not remember any subsequent or secondary symptoms, except that eleven years after he had a severe sore throat, lasting two months, which was then attributed to exposure while following his work. He has been subject to rheumatic swelling of the larger joints, but the affection has never been so severe as to keep him in bed. The present illness began about two months before admission, and followed unusual exposure during rainy weather. The first symptom complained of was constant pain in the head, which became more severe at night, and generally kept him from sleeping until morning. Two weeks later, he several times vomited a dark yellow bitter fluid, and his stomach became very irritable, rejecting everything, the nausea frequently requiring him to get up at night to vomit; he now noticed that he had a bad taste in his mouth, and that all his food seemed alike; even pickles had a sweetish taste. His skin soon became yellow, and when he applied for admission, presented the appearance of marked jaundice. His conjunctiva was slightly discolored; his tongue was furred, dryish, and yellow; he had no appetite, and the bowels were constipated. He had previously experienced occasional attacks of epistaxis, but there was no pain in the right shoulder, nor fever; tenderness was found in the hepatic region upon percussion, which, however, yielded no evidence of any abnormality in the size or shape of the organ. The headache continued severe for a week after admission, while his general condition rapidly improved. Under bicarbonate of soda and laxatives, with rest in bed, and an occasional anodyne at night, the patient steadily got better; the jaundice faded, the general condition was decidedly better, and, in short, he was considered convalescent, although still confined to bed, when, without premonition, yesterday afternoon, he had a convulsion, accompanied, or speedily succeeded, by unconsciousness, stertorous respiration, frothing at the mouth, with bloody sputum, congestion of the features, slightly dilated pupils, and clonic spasm of the muscles of the extremities, with a pulse of 120, but without elevation of temp-

erature. This passed off soon, but in the next twenty minutes he had two more such seizures, in which it was noticed that there was now some loss of expression on the left side of the face, and drooping and twitching of the corner of the mouth. The urine was tested and was found non-albuminous. In spite of bromide of potassium freely administered, stimulating enemata, and a blister to the neck, three more convulsions came on during the night, at short intervals, in the last of which the head was drawn strongly to the right side and downward.

This morning he is in the condition that you now see, conscious, but perfectly helpless. The pupils are contracted evenly, the pulse is 112, full, and moderately strong.

In proceeding to a physical examination of this paralyzed patient, the first point that we notice is, that his intelligence is good. He follows my movements with his eyes. He can open his mouth, and even, with some little hesitation, he is able to slowly protrude the tongue. The grasp of the left hand, although not strong, is distinct, but there is no power at all in the right. As regards the legs, he cannot move the right one at all; reflex movements, likewise, are almost entirely abolished. Although he lifts the left leg at command, yet he evidently does not move it as readily as he does the corresponding arm. From his prompt obedience, I can testify to his active intelligence, speechless as he is and only giving utterance to a few inarticulate sounds when he tries to answer a question. The loss of voice in this case is not due to simple paralysis of the muscles of articulation, as he can open the mouth, protrude the tongue, and swallow medicine or drink. This is evidently a case of acute aphasia, or loss of articulate language, in which there is also some facial paralysis and right-sided hemiplegia.

We have now established the following points. A patient with constant headache, with an obscure history of syphilis, while recovering from an attack of catarrhal jaundice, is seized with convulsions. Notice, that with unimpaired intelligence and memory, there is loss of articulate language, and of motion on the right half of the body; sensation is not much impaired, if at all. We have tested the urine, and have found no evidence of disease of the kidneys. Examining his heart, I find no signs of valvular disorder. The liver and spleen show no marked enlargement and no dropsy is present, neither ascites nor œdema.

In searching for an explanation of this case, we first recall the fact that where there is much bile in the blood we may have disorder of the brain. But cerebral jaundice is not so apt to be attended by convulsions as it is by slow pulse, stupor and coma, passing into death. I may mention, in leaving this point, that jaundice never causes brain symptoms, unless it is strongly marked; in this case they did not come on until the jaundice had nearly disappeared. In uræmic convulsions we would have albuminuria at some time in the case, but here, I may add, repeated examinations have failed to detect any albumen. We may, therefore, consider the kidneys as thrown out of the question.

What, then, is the matter with our patient? We cannot well ignore the paralysis, nor the aphasia; but to what can they be due? In my opinion, the source of the trouble may be found either in acute and localized congestion of the brain, or effusion, perhaps with a small clot, and the situation of the morbid action is in the left anterior hemisphere.

Now, there are two opposite views of the cause of the convulsions that might be taken; first, the congestion was the cause of the convulsions; or, secondly, the convulsions produced the congestion, the convulsions themselves being due to some other cause, such as a cerebral tumor, or similar growth.

We must now try to determine, first, if the muscular spasm was caused by the congestion, or due to brain-tumor. I hold to the latter view, because such attacks are not often due to mere congestion of the brain. Not a very striking reason, it is true, but I think we have more positive evidence in the fact that there must exist some cause for the attack. Remember that it came on while he was doing very well, lying quietly in bed, and without any external disturbing element. But on recalling his history, we find the view of an original brain disorder confirmed by the persistent, severe and localized headache, which now becomes significant. I believe that we have here to deal with a small growth, probably syphilitic, either in the meninges, or in the brain substance, giving rise to an acute attack of congestion and effusion. For further confirmation of this view, we will have his eyes examined with the ophthalmoscope.*

Now what is the prognosis; what is going to happen in this case? Is it to be speedily fatal, or will he remain a helpless and permanent paralytic? From the view I take of the case, I believe that he will get speedily well, that he will get entirely over the acute attack. We will then look after this small growth, and endeavor to prevent further return of the convulsions.

To help the patient through the present attack, we will keep up a rather free purging, and for this purpose he shall take powders of rhubarb (grs. x) and calomel (grs. v), several times daily, until the desired effect is obtained. The bromide of potassium also will be useful, to relieve the congestion; of this he may have thirty grains at night. We will also endeavor to control the circulation and start the kidneys, by ordering—

℞.	Potassii acetat,	grs.xx	
	Tr. aconit. rad.,	gtt.iij	
	Syrup zingiber,	ɱxxx	
	Aqua, q.s. ad.	fl.℥ss.	M.

Sig. To be given thrice daily.

* It was afterward found, on attempting to examine the fundus of the eye, that so high a grade of astigmatism was present as to prevent such a view as would be conclusive, until the astigmatism was corrected by appropriate glasses.

He shall have another blister to the back of the neck, and an ice cap, being careful, however, not to freeze the scalp by its careless application. In a few days I propose to substitute for the acetate the iodide of potassium, in gradually increasing doses, partly to aid the absorption, and partly to directly affect the growth. It has earned an extended reputation in the therapeutics of brain tumors, but more especially in those of syphilitic origin, where it stands without a rival.

[Four days later it was noted that the aphasia and paralysis had both disappeared, and his condition was steadily improving. The acetate was then exchanged for the iodide of potassium, in ten-grain doses four times daily, under which he rapidly became convalescent. He had no further bad symptoms, and was enabled to return to his work, January 13th, 1877, apparently in excellent health.]

Ergot in Pulmonary Hemorrhage.

I wish to use the next case to illustrate the powers of the fluid extract of ergot in controlling hæmoptysis. This patient was before you at the last clinic, spitting blood. He was then ordered to be frequently dry-cupped, and directed to take the ergot in drachm doses. After taking four doses at intervals of three hours, the bleeding stopped, and he has had but one small hemorrhage since. He has still a cough, but it is attended only by the ordinary mucous expectoration. We will now give him, partly as a tonic and partly as an astringent, to prevent a return of his trouble, the dilute sulphuric acid, ten drops four times daily; and as soon as we find he can bear it we will put him on small doses of arsenic. I do not think that there are tubercles in his lungs, but even where there is no apparent inherited tendency, it is well to keep this possibility in mind; the cough might terminate in tuberculosis; and, therefore, as soon as we find his stomach will bear it, we will give him cod-liver oil.

Abdominal Aneurism of Aorta—Remarkable Result from Iodide of Potassium.

Before examining this patient, I will call your attention to some points in his previous history. His notes on admission state that his name is Frank McC., a laborer, and a native of Ireland. He is 52 years of age, and naturally of strong constitution. There is no known inherited tendency to any form of disease in the case; but the patient himself has been intemperate, and eleven years ago became inoculated with syphilis. He has since then had an eruption on his skin; and his wife has had a number of miscarriages. Nine years before admission he had an attack of smallpox, accompanied by severe lumbar pains, but has since been fairly well, until three years ago; when, following exposure to bad weather, he had severe lumbago, which did not yield to treatment. A year later this symptom became so aggravated that he was obliged, frequently, to sit up at night, the pain being unbearable when he was lying down. It should be stated that at this time, and previous to it, he had been working very hard at heavy labor and lifting. Six months afterward he noticed a pulsation in his stomach, accompanied by dull pain, increased after taking food. He also had troublesome nocturnal dyspnœa, that prevented him from resting in his bed, for weeks at a time. He never had rheumatism nor lancinating pain anywhere; but this aching pain in the back sometimes extends around at the sides, so as to give him the sensation of having a cord around his waist. If we add to this brief outline the fact that his bowels generally have been constipated, we have a fair idea of the course of his disease.

Removing the clothing from the patient's abdomen, and regarding the pit of the stomach attentively, you perceive the source of the symptoms just described to you, announced by considerable beating. The impulse is quite marked to the hand, but I cannot say that it is associated with thrill; and the throbbing is less marked in the erect posture than when he is lying down, but still no thrill is developed by the change of position. By percussion, we find the area of dullness outlines a tumor in the epigastric region, occupying, generally, a central position, but extending further to the right side than the left, and from the ensiform cartilage nearly to the umbilicus. To the right, the impulse is more expansive than to the left. Placing a stethoscope over the point of greatest pulsation, I distinguish a short, rather harsh, mitral, systolic murmur in the tumor; and proceeding to examine posteriorly, I find the same distinct, hoarse, short, single murmur, more marked than in front, heard best to the left of the vertebral spines, on a level with the upper lumbar, or lowest dorsal vertebra. In this location he also complains of tenderness when I press upon it, but I can discover no abnormality of the bone. Listening to the heart, I find evidence of a certain amount of hypertrophy with dilatation, and a faint systolic apex murmur.

I have said that this is a case of abdominal aneurism. I will now give my reasons for doing so, and see if this diagnosis will explain all the symptoms. Fortunately, for demonstration, this is a case more easy to diagnosticate than most cases of aortic aneurism in this situation. Ordinarily the diagnosis is beset with difficulties, and at times the disease is so obscure as to elude even skilled observers. In general terms, the diagnosis may be said to be based upon—1, extended impulse; 2, murmur and thrill; 3, increase in percussion dullness, or, in brief, the signs of a swelling. What adds to the difficulty is, that extended impulse may be a symptom of mere sympathetic or nervous palpitation, especially in excitable women, where it may be found to exist in even a more marked degree than in the patient before you. Such cases are distinguished by absence of murmur, and more especially thrill, and there is no increase of percussion dullness.

It is true that an anæmic murmur may complicate the case, but the character of the sounds furnished, and their presence in the vessels of the neck, and elsewhere, will give the clue to the true cause.

A more difficult differential diagnosis is that between abdominal aneurism and an overlying tumor pressing upon the aorta and transmitting its pulsations. This will give extended percussion dullness, extended impulse, and, perhaps, a blood murmur; but the early history and the progress of the case will be of great assistance in deciding upon the disease. I will give you one point, however, that should be borne in mind: one of the most constant signs of abdominal aneurism is pain in the back; remember this fact, and search for this marked symptom, as well as for tenderness on pressure. Another mark is found in the existence of a murmur, which is most distinctly heard at the back of the patient.

In this case we have an amount of dullness and expansion that can scarcely be confounded with anything else. But why is there no thrill? While thrill frequently accompanies abdominal aneurism, there are cases which attain a large size without it. The absence, then, of thrill, is no conclusive evidence on the other side.

Briefly to review the case, we have an abdominal tumor, with throbbing, murmur, dullness, with the general appearance of a tumor; in other words, we have the signs of abdominal aneurism. There are a number of other confirmatory points that I will not have time to dwell upon.

Notice, however, that there is no cachexia present, nor would we expect it in such a case, except from pressure upon the thoracic duct.

Now, to consider the cause. The patient is not an old man; there is here no senile degeneration of the vascular walls. He has had some hard laboring work, but he had pain in his back before. Let me state, broadly, that where abdominal aneurism occurs in early life, or beginning middle age, it is likely to be due to syphilis We read of its prevalence among soldiers, from this cause.

You must not suppose, however, that syphilis directly produces aneurism, but that the vessel gradually undergoes degeneration, by which its fibrous tissue is weakened and is prepared to yield suddenly under unusual strain or lifting work, or the other coats have less resisting power, and gradually give way. Syphilis is thus a very positive and active predisposing cause of aneurism.

Having discussed the pathology, we will briefly turn to the treatment The first principle is rest; the patient must be kept in bed, and not allowed to get up until the disease is under control. He shall have a moderate amount of nourishing food, sufficient at all events to make fibrin enough for the blood, so as to favor coagulation on the inside of the sac. While the pulse continues above 60, give him two drops of tincture of aconite each night. His bowels must be kept open, daily, with Seidlitz powders. He must, under all circumstances, be cautioned to avoid all strain, by lifting or in defecation, and lead a quiet life, mentally and bodily.

It should be stated that the patient has been previously under treatment at this hospital, last spring, and was discharged, after four weeks' care, greatly improved by iodide of potassium, in ten-grain doses, thrice daily. He has also been taking this during his present stay in the ward. We will now double the dose, and direct it to be given in increasing amounts, until some effects are noticed.

The explanation of the treatment by iodide of potassium is suggested by what you know of the primary cause of this trouble; but apart from this, the iodide, in decided doses, has been found to be an excellent remedy in abdominal aneurism It is not an old one, having been much used only for five or six years, but a number of cures from its employment have already been reported, of which I have had one. Some observers think that it acts by favoring the absorption of the lymph and leading to its reorganization; while others hold that it encourages the deposit of fibrinous layers on the inner coat of the aorta, thus diminishing its size and leading to contraction. But, however this may be, we have sufficient evidence to establish the claims of potassic iodide as a valuable remedy in abdominal aneurism.

[The patient was treated as directed. the iodide being cautiously increased to three drachms daily, which he took without inconvenience for more than a week. As the greatest improvement was now noticed in the aneurism, the dose was reduced to 100 grains per diem, which he was taking at the time he was again shown to the class, January 20th, with the tumor much reduced in size, the throbbing scarcely discernible, and all pain and inconvenience gone.]

Medical Societies.

PROCEEDINGS OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY.

REPORTED BY DR. FRANK WOODBURY.

Conversational meeting, held December 27th, 1876. Dr. Thomas M. Drysdale, President, in the Chair.

Dr. S. D. Risley read a paper entitled "A Clinical Study of the More Frequently Occurring Forms of Conjunctival Disease," for which a vote of thanks was tendered the author.

Dr. William Goodell remarked that he had come to the meeting from a sense of duty alone. He was not familiar with even one-half of the terms used by ophthalmologists, and the whole subject of eye diseases was, to him, an arid one. But, to his surprise, he had found himself

deeply interested in the very instructive paper just read. There was but one criticism he wished to make, and that was the omission, on the part of the author, to touch upon the only form of conjunctival trouble which more especially passes under the attention of the general practitioner. He referred to *ophthalmia neonatorum*. For this troublesome affection he had drifted into a routine treatment, which had thus far given him very satisfactory results. Thrice daily were the lids parted, and the eyes syringed out with a saturated solution of alum. To this simple treatment a large majority of cases quickly yielded. But when the disease proved stubborn, he, in addition, instilled into the eye, once daily, a solution of twenty grains of the silver nitrate to the ounce of water, taking care afterwards to decompose the excess by brushing the lids with a saturated solution of table salt. Out of a large number of cases thus treated, he had but one of failure to report. In this case the child became blind. It died shortly afterwards, from congenital syphilis, which was the cause of the ophthalmia. He was glad to find that Dr. Risley advocated the local use of iodoform in photophobia. He himself had been led to think that it would do good in this affection, for there was no better local anæsthetic. The proportion of one part of iodoform to two or four of lard had proved of signal service in the treatment of chapped nipples, while a suppository containing five grains would always allay the pain of an anal fissure, and sometimes cure the disease.

Dr. Benjamin Lee inquired whether division of the external canthus was the accepted treatment of those cases of strumous ophthalmia, where there is spasmodic twitching of the orbicularis, and in which the morbid action is sustained by the rasping of the inflamed tarsal conjunctiva over the globe. He would also ask in regard to the treatment of those cases of conjunctivitis which are accompanied by disease of the nasal passages, as in hay fever. In the last-named trouble he had seen marked results from the insufflation of a quinine solution.

Dr. Risley, in the cases of spasmodic closure of the lids, had been disappointed with the operation of section of the canthus, but had found that it, with the other symptoms, usually subsided under treatment by atropia; after the inflammation is reduced, if the spasmodic element continue, douches of cold water will often quiet the twitching of the orbicularis, but only temporarily. In chronic granular conjunctivitis, with pannus, canthoplasty will often lead to a cure in a few weeks, when other efforts have proved abortive.

Dr. C. R. Prall has used the steam atomizer, with a solution of sulphate of zinc, with good results, in hay fever, the vapor being snuffed up the nostrils.

Dr. John G. Stetler had found signal benefit in a similar case from a constitutional impression with iodide of potassium, followed by atropia.

Dr. S. D. Risley desired to know the relative frequency of the occurrence of conjunctivitis in hay fever. The German writers mention a spring catarrh which is not seen in this country; perhaps it may be the analogue of our hay fever.

Dr. D. G. Brinton is annually called upon to treat five or six cases of hay fever, and had found that in each, if allowed to go on, the conjunctiva became finally involved, the conjunctivitis being secondary. He had faithfully tried arsenic, and iodide of potassium, without result. Quinine had failed him entirely; carbolic acid and sulphate of zinc have a soothing influence upon inflamed mucous membranes, and might give some relief in hay fever, but they certainly are not specifics. He had not been able to find any spores or distinctive microscopic character in the discharge, although the disease is undoubtedly due to some vegetable exhalation. As it may come on at any time during the summer, the term hay fever is a misnomer; in susceptible individuals dust will cause the disorder at any season of the year. It is a neurosis connected with constitutional idiosyncrasy, dependent upon a cause whose effects are invariable and not susceptible of cure, the only successful means of relief being the removal of patients from the neighborhood of the irritant. He has never seen a case cured, and Dr. George N. Beard, the author of an excellent monograph on this subject, has expressed the same opinion.

Dr. F. Woodbury had observed, in a case of strumous conjunctivitis, after applying the collyrium, that the saturated solution of common salt caused more complaint of burning than did the weak silver solution employed; it seems as if, in some cases, the saturated solution might produce so much irritation as to more than counterbalance the good from the caustic. He thought that the weak solutions of silver would not generally require neutralizing, but that when the chemical antidote was employed for this purpose, a larger quantity of a weaker solution, say about the density of the tears, would, perhaps, give equal satisfaction to the surgeon and more comfort to the patient.

Dr. S D. Risley endorsed the treatment recommended by Dr. Goodell. Mild measures are not only safer, but more successful. Having seen a case where inoculation of a nurse's eye occurred from the recoil or splashing of fluids from the eye of the child when a syringe was used, he now discards the syringe, and uses, instead, a pipette, as with it sufficient force could not be exerted to endanger a recoil of fluids. In the treatment of the purulent ophthalmia of new-born children, great cleanliness is essential. He preferred the mitigated stick of nitrate of silver, carefully applied over the conjunction of the everted lids, which should be previously cleansed, the surplus of the silver being neutralized by a saturated solution of common salt, so that the caustic shall not injure the cornea. He has instilled weak solutions of nitrate of silver in such

cases, and rubbed it about in the eye, by a finger on the lid, to insure its general action, but prefers the previously mentioned treatment. Some of the best results in the treatment of this disease he had obtained from a twenty per centum solution of carbolic acid in glycerine, which gives rise to less protracted pain than the nitrate.

Dr. Washington L. Atlee, in former years, had seen a number of cases of babies' sore eyes. Almost every case taken in its incipiency yielded rapidly to the application of a twenty-grain solution of nitrate of silver, dropped in the inner canthus, rubbed well around in the eye, and not neutralized by salt. Cleanliness was insisted upon.

He was pleased with the views expressed by the lecturer in regard to strumous ophthalmia, which differed essentially from those of the older writers. In such cases fresh air, tonics, and cod-liver oil are the more important part of the treatment.

EDITORIAL DEPARTMENT.

PERISCOPE.

On Trephining in Fracture of the Cranium.

M. C. Sedillot, in the *Gazette Medicale*, has recently put forth a further contribution in support of his view, that in fracture of the internal table of the cranial vault, with displacement of fragments, trephining is the only means of preventing complications that are almost invariably fatal. Of 106 cases of fracture of the cranium collected by the author, there are seventy-seven in which trephining was practiced, and twenty-nine in which no operation was performed. In nine cases the operation was preventive, that is to say, it was performed before the manifestation of any bad symptoms. In sixty-eight cases it was curative, and had as its aim the relief of serious complications, such as paralysis, loss of consciousness, convulsions and coma. In twenty-one of the latter set of cases the operation was performed before the receipt of injury, and in the remaining forty-seven cases after this period. In all the 106 cases the internal table was fractured. In twenty-one cases the external table was not involved, and in most of these the symptoms were so slight that the gravity of the injury was overlooked.

Out of the twenty-nine cases of comminuted fracture of the inner table in which trephining was not performed, there was one recovery only and twenty-eight deaths. Of the seventy-seven patients who were trephined, thirty recovered and forty-seven died. In nine of these cases the operation was performed for prevention of serious symptoms; in six with success, in three with a fatal result. In sixty-eight cases the operation was curative, and resulted, in twenty-four of them, in recovery, and in forty-four, in death. Of the twenty-one cases in which the operation was performed before the sixth day from the date of injury, eight ended in recovery and thirteen in death. Of forty-seven patients trephined on or after the sixth day, fifteen recovered and thirty-two died. The mortality, M. Sedillot points, bears a direct proportion to the delay in the application of the trephine. Two-thirds of the number of patients were cured by "preventive" trephining, more than one-third by *early* trephining (before the sixth day), and less than one-third by *late* trephining (on or after the sixth day). Of the twenty-nine cases in which the operation was not performed, one only ended in recovery. These figures show, according to the author, that comminuted fracture of the inner table of the skull is an injury almost invariably fatal, unless the fragments are elevated or removed.

The Management of Condylomata.

Mr. G. R. Gilruth, of Edinburgh, says, in the *Medical Journal*, of that city, December, 1876:—

Many escharotics have been recommended, but after the excrescences have been touched once or twice with the nitrate of silver, the most potent seems to be nitric acid. This acid, with the exception, perhaps, of the first application, does not cause great pain, and by using oils, protection can be given to the healthy skin. Likewise, any irritation may be allayed, and the raw surfaces prevented from rubbing against each other, by applying cotton-wool soaked in black-wash, with gutta-percha tissue over it, and then securing this dressing by a handkerchief passed between the hips and fastened in front and behind. The acid seems to act not so much by destruction of tissue, as by causing dispersion of fluid.

The following case will be given, to exemplify this mode of treatment:—

M. B., a young gentleman, called on the 14th of July, 1875, on account of some growths about the anus. When the hips were held apart, a very disgusting appearance presented itself. The skin on each side of the anus was raised into red, raw-looking, damp ridges, whilst a number of smaller condylomata were found scattered over the nates. These excrescences had existed, he said, for about three months, and had resisted an application which he had been ordered by a

medical gentleman to apply. He suffered much pain, could hardly sleep at night, and during the day sat with difficulty. On his penis were several soft chancres, and on various parts of his body a pinkish rash.

The excrescences were touched during the first few days with nitrate of silver, and after the skin was smeared with oil, nitric acid, by means of a rod, was applied every second day; cotton-wool soaked in black wash being placed between the buttocks, and retained there by a bandage, and used as a dressing.

21st July. Much reduced in size, being almost level with the sound skin.

29th July. With the exception of the merest vestige of one, the others had vanished, and the skin which corresponded to the situation of the excrescences had resumed its natural appearance.

The chancres were treated locally, and soon healed.

A Case of Complete Ablation of the Uterus.

An apparently successful case of complete excision of the uterus, for cancer, was reported to the last meeting of the German Society of Physicians and Naturalists, by Dr. Hennig, of Leipzic.

In the performance of the operation the uterus was first separated from its connections with the anterior wall of the vagina by a knife and scissors; next it was separated by the fingers from the anterior fold of the peritoneum; and then, since the vessels in the broad ligament bled but little, the fundus of the uterus was drawn forward, first with two fingers and afterward with a hook, so that its connections with the posterior wall of the vagina were divided without difficulty. The growth had invaded the posterior vaginal wall, and one tubercle involved the wall of the rectum, and in its removal a small opening was made in the rectum. The total length of the uterus was five and a half inches, and the carcinoma had invaded the whole cervix. It was found that the left ovary and Fallopian tube, adherent to the uterus, had been removed with it, and about one-half of the right Fallopian tube. Thus the uterus had not been separated from the peritoneum, as intended, but the tissue which was attached to the base of the uterus showed that old peritoneal exudations had filled up and enclosed the pelvic portion of the peritoneal cavity, in consequence, no doubt, of perimetritis. The opening in the rectum was closed with the needle, and a piece of ice put into the wound; there was little subsequent hemorrhage, and the wound was cleansed afterward by injections of salicylic acid twice a day. Considerable peritonitis followed, the temperature of 105° being reached on the fifth day after the operation, but it gradually subsided. The recto-vaginal fistula was closed by an operation four weeks after the excision of the uterus, and with the exception of a small superficial abscess from some enlarged glands, the patient's progress was most satisfactory. Four months later a small soft growth appeared in the neighborhood of the fistula, and was removed without difficulty, the fistula having become almost closed; and up to the date of the communication, eight months after the operation, no further symptoms of recurrence had manifested themselves, and the patient's health continued good.

On Psoriasis of the Tongue.

The following general conclusions are given in a contribution, by Dr. Nedopil, to Langenbeck's *Archiv*, of Vienna, on psoriasis of the lingual and oral mucous membrane, and on the relation of this affection to carcinoma:—

1. Psoriasis of the mucous membrane of the tongue and oral cavity is caused through a chronic inflammatory process which takes place in the proper mucous layer.

2. This chronic irritative process results in a new formation of young indifferent cells.

3. These indifferent cells, which lie near to the epithelial layer of the mucous membrane, are converted into true epithelium; hence results the formation of patches of abnormal, bulky and rapidly regenerated epithelium.

4. The epithelial layer of the mucous membrane, as in the normal condition of things, remains quite passive, and takes no part in the regeneration of these patches.

5. The deeply-seated indifferent cells of new formation are partly converted into shriveled, scar like tissue, and partly persist as round cells, which may finally displace the proper tissue of the mucous layer.

6. These indifferent cells, when in the substance of the mucous layer, and before they have attained their ultimate position, may acquire an epithelial character, and thus carcinoma is developed.

7. When carcinoma is developed from indifferent cells, they take on the mode of nutrition as is met with at other times in the surface cells.

The Results of Nerve Injury.

The following remarks were made by Mr. Gay, at the Northern Hospital, London, in a recent clinical lecture, reported in the *Lancet:*—

The results of nerve injury from accidents and operations are interesting. The division of considerable nerve-branches—such as (1) those we are more familiar with—viz., the ulnar and the peroneal; (2) of smaller branches, filaments, or twigs, near their peripheral termination, as in ordinary operations or wounds, or in skin-shifting; and (3) of sympathetic branches, as by experiment—is followed by curious results. In the first, the parts to which the divided nerve is distributed may suffer permanent or only temporary loss of nerve power, or that power may be partially recovered; in the second, in the course of severe wound, such as that just related, no

results attributable to nerve lesion can usually be detected; whilst in skin shifting the effects of nerve lesion may or may not follow. In some instances, as in those about the neck, when not very extensive, they do not; neither do they usually about the face; but in the shifting of flaps, such as from the forehead. for the formation of an artificial nose, they do follow. But in such cases the result is generally in the form of hyperæsthesia: the nose "feels cold"—resulting, probably, from increased sensibility to the atmosphere; but it resents wounds and other painful injuries as usual; and this often passes away to a considerable degree. In one case, that of a gentleman from America, whom Mr. Gay saw for an incurable ulcer at the base of the great toe, the toe, from about the termination of the metatarsal bone, was devoid of all sensation. The case is worth brief narration. After making every attempt to cure the ulcer, which was about the size of a sixpence and deep, Mr. Gay cut it fairly out with its tissues, and, after liberating the edges by deep lateral incisions, brought the wound together by sutures. It healed, as did the lateral incisions; but it was replaced subsequently, by another ulcer of exactly the same kind and size. The tissues were wholly insensible during the operation. The anæsthesia was occasioned, the patient said, by removal of the toe nail twelve years before.

In experiments on a sympathetic branch, definite and well known results follow; but the like results do not seem to follow division of its peripheral nerve-filaments, nor do analogous results constantly follow division of the nerve-filaments of the ulnar or peroneal in the event of their division at this part of their respective courses.

Now do not these facts show that, whilst in wounds of nerve-branches of a certain size, and at a certain distance from their peripheral termination, certain functional disorders inevitably follow, the like results do not follow division of their ultimate fibrils? In other words, do they not render it probable that there is, in the periphery of the nervous system, a certain zone in which the insularity in point of conduction, which is so marked in every other part, especially as the nerve-branches approach the nerve-centres, does not exist; and that thus the function of one nerve-fibril would instantly be undertaken by another, in case of its being interrupted?

A Wonderful Tale.

That veracious and high-toned sheet, the New York *Sunday Mercury*, has printed a long account of "A Boarder's Awful Fate," from swallowing a cherry stone, which sprouted in his stomach and grew so vigorously that it killed him! An Illinois physician writes us the story is attracting much attention in his vicinity. He can assure these anxious souls that boarding house pies are often dangerous, but not in this way.

Reviews and Book Notices.

BOOK NOTICES.

Civil Malpractice; a Treatise on Surgical Jurisprudence; with chapters on Skill in Diagnosis and Treatment, Prognosis in Fractures, and on Negligence. By Milo A. McClelland, M. D. New York, Hurd & Houghton, 1877. 1 vol., 8vo, pp. 554. Price, cloth, $3.50; sheep, $4.50.

Dr. McClelland here presents a very useful volume. It is a collation of leading cases in alleged surgical malpractice in this country, with a few chapters on suits in obstetric, medical, and miscellaneous cases.

There is a growing tendency to hold the physician pecuniarily responsible for the possession of skill, and the exercise of sufficient care in his attendance on his patient. Though this, at times, bears hardly on honest workers in the profession, it is probably, on the whole, a benefit, as a deterrent to recklessness on the part of ignorant pretenders.

On the other hand, it is not pleasant, in looking over the causes tried by the various courts, to observe how often very obvious quackery has escaped scot-free. Juries seem to have a tendency to lean against scientific medicine, and favor an unblushing charlatan.

The first chapter contains a number of legal definitions, by no means the least valuable part of the volume. From it we learn that, as the law does not recognize systems of medicine, to term a person a "quack" is to charge him with a want of necessary knowledge to practice the system of medicine to which he belongs. As by a New York ruling (p. 4, note) a "medical clairvoyant" is a recognized practitioner, entitled to recover for professional services, and as it would be an arduous undertaking for any one to say how much knowledge it requires to practice that system, we had better all be cautious how we apply the opprobrious epithet referred to.

Interesting rulings are given as to the powers of Medical Societies over their members, confirming the unpopular position taken by this journal some years ago, in regard to the New York County Medical Society.

About one-half the book is devoted to alleged

malpractice in fractures and dislocations. Chapter xvi gives a series of tables from Dr. L. A. Sayre and Frank H. Hamilton, on Prognosis in Fractures. They have been published before, but are not of convenient access, while their value is great. Skill in diagnosis, skill in treatment, and negligence, are treated at considerable length, in separate sections. The book is a very valuable addition to the literature of jurisprudence in America. It is on sale by T. and J. W. Johnson, Philadelphia.

Johnson's New Universal Cyclopedia. Volume I. A–E. A. J. Johnson & Son, New York City. pp. 1696.

Among the several encyclopedias which now dispute the American market, the one whose title is placed at the head of this notice justifies, in many respects, its claims to preëminence. It is as far superior to Zell's Cyclopedia as Trousseau's "Clinical Lectures" are to old Gunn's "Domestic Medicine;" compared to the unwieldly and costly Encyclopedia Britannica, it is what an American trotting wagon is to the lumbering mail coach; while its more formidable rival, Appleton's "New American Cyclopedia," is not only three times more in price, but is notoriously disfigured by partisan views in a number of its historical articles, and unfavorable discriminations in regard to contemporaries. On the whole, we have no hesitation in commending Johnson's as the most desirable work of its class to own that is now to be had.

The editors-in-chief are Dr. Frederick A. P. Barnard, President of Columbia College, and Professor Arnold Guyot, the eminent physicist and geographer. The articles in different departments of science are placed under the charge of associate editors, chosen from the most distinguished in the various branches. Thus, to confine ourselves to subjects more particularly germane to our own profession, the department of Medicine, Surgery, and the Collateral Sciences is under the charge of Dr. Willard Parker; Botany and Vegetable Physiology under Prof. Asa Gray; Chemistry and its Applications under Prof. Charles F. Chandler; Comparative Anatomy and Animal Physiology under Prof. Theodore Gill; Meteorology, Electricity and Magnetism under Prof. Joseph Henry, of the Smithsonian.

From this selection it will be seen that the corps of editors guarantee the quality of the work to be all that it should be. In our notice of the next volume we shall take up the individual contributors to the medical department, and examine how thoroughly this branch of learning is set forth.

Johnson's Encyclopedia will be completed in four volumes, large octavo, nearly two thousand pages each. It is sold by subscription only, the price of each volume ranging from $10.75 upward, according to the binding. Residents of Philadelphia can have the agent call upon them by sending a card to this office; others can address the publisher, who will see that they are shown the work.

Aids to Anatomy. By George Brown, M. R. C. S., L. S. A. Late Demonstrator of Anatomy at Westminster Hospital Medical School; Gold Medalist (1873) Charing Cross Hospital; formerly Prosector of Anatomy at the Royal College of Surgeons of England, etc. Cloth, 12mo. For sale by D. G. Brinton, 115 South Seventh street, Philadelphia. Price 60 cents.

It is certainly pleasant to witness any ingenuous attempt to aid the student in his early steps in the pursuit of his profession. Such an attempt has been made by the author of a little pocket manual of sixty-four pages, with the above heading. With the author we fully agree that anatomy is no more difficult for the mature mind of the medical student than geography for school children; and we think he could have gone further, with justice, and said that anatomy in all its details presents no greater difficulties, nor does it require more memory or perseverance, than the study of geography.

In the preface of this pamphlet, we find that the work was prepared in his student days, and first appeared in his note book. As a plan of note-taking it is worthy of the student's perusal, for we firmly believe that the pen makes one exact, and is a great aid to the memory.

No one with an honest desire to aid his fellowmen will enter the medical profession without a careful study of the first and most essential of books, Anatomy. This study the author is careful to recommend, but his error lies in limiting his abstracts to too few departments of anatomy, as if one were more important in its bearings than another. About half the pamphlet is devoted to special regions, and the remainder to the nerves; these evidently being the average student's vulnerable points on passing his medical examination.

THE

Medical & Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders be drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

REMARKS ON WRITING FOR THE MEDICAL PRESS.

Much of the value of accurate observation depends on the skill with which the observed facts are arranged and presented to the minds of others. The lessons of experience are of small worth, even to the individual, unless he can so express them as to engage the consent and co-operation of others. In professional consultations, it must have been a not infrequent occurrence to all to witness a flimsy hypothesis, plausibly presented, overweigh the solid dictates of experience awkwardly stated. Hence it should be a prominent feature in the self-education of professional men, to mature and arrange their knowledge so that it will be in the highest degree available. The editor of a scientific journal has occasion constantly to compare reports of observations from different pens, and to perceive how often writers bury their wheat in a multitude of chaff, to the great detriment of themselves and their readers. Some mention of the more common of such errors will not be out of place.

The first and most distressing to such an editor is an effort at *style*—that is, the effort, not so much to tell facts, as to tell them in a particular manner. Thus we have seen reports of clinics where the patients were described in the phrases of a dime novel. Chlorotic girls had "pale and anguish-stricken countenances;" long malady had preyed on their "once damask cheeks;" hysterical women had been "rent and torn by strong emotion;" a case of delirium tremens had "struggled in vain against the hellish charms of the intoxicating bowl;" and so on. Such absurdities inevitably condemn the article to limbo.

In other instances the writer aims to relieve his subject by a flow of humor. His description of the patient is enlivened by jocose remarks on his appearance, or by describing some amusing occurrence in connection with him. While this is not always, and in every instance, to be condemned, it is very generally out of place, and should be avoided; and always and invariably so where the relations under discussion are those of the sexes; for nothing is more thoroughly distasteful to the man of culture than to meet equivocal jokes or coarse ambiguities in a scientific article.

Next is *diffuseness*. It is so much easier to climb by a circuitous path than to walk straight up, that the first draft by an unpracticed writer is certain to be at least double its proper length. In reporting cases it is not necessary to detail pulse, temperature, respiration, etc., at each visit, but only where such changes bear on the lesson the report designs to teach. Often extraneous matter about irrelevant previous history, or other patients, is inserted, which has no business in the report at all. There are very few articles in medical journals which should exceed eight or ten foolscap pages in length. Let every writer consider this his extreme limit, and if his pen inclines to go beyond that, let him unflinchingly strike out his paragraphs.

Diffuseness is greatly encouraged by *quotation*. Every physician should take for granted that his readers have read and own several standard text-books; hence it is worse than useless to quote long paragraphs from them, when a mere reference, or at most, a very terse abstract, would be ample. Moreover, science does not much respect authorities, and an argument based on them had better be suppressed altogether.

In this respect many papers err, through *absence of original investigation*. For the thesis of a student it may do very well to collate the opinions of a dozen or twenty authors; and an excellent class of medical periodicals and books cultivate that field exclusively; but such "reports of progress" do not belong to the department of "original communications" in journalism. What is wanted, is, for the writer to give the fruit of *his own* observation, and give it *briefly*.

A disagreeable fault in quotation is the use of hackneyed common places, such as "the ills which flesh is heir to," "knowledge is power," and the like. They add nothing to strength, and fall on the reader's palate with the stale flavor, as Juvenal expresses it, of "twice-cooked cabbage."

All *personalities* should be rigorously excluded. Scientific men are often sensitively jealous; and physicians are liable to suffer in purse when their scientific knowledge is proved at fault. The lapsus is told their patients by a competitor, and these desert them. But for all this, nothing is gained by increasing hostilities. As for "showing up" quacks, an extended observation inclines us to believe that, as a rule, the more they are shown up, the more they thrive.

Some minor oversights are also enough to lead many an editor to reject an article, on acccount of the needless trouble they cause him. Every one who writes for the press should use *black ink* and *white paper*, not lead pencils, nor colored sheets, which render even a good hand illegible; he should *never* write on both sides of the same sheet, for good and sufficient reasons, known to every printer, and needless to explain; he should *never* end his note to the editor with words to this effect:—"I have written the enclosed paper in a great hurry, and have not had time to correct it Please do it for me." The editor, nine times out of ten, has a great deal more to do than the writer, and if the latter doesn't take the trouble to clothe the progeny of his own brain in proper garb, he can't expect others to do it for him. Whatever is sent in should be carefully prepared and clearly written.

Notes and Comments.

A Metrical Tape Measure.

The engraving we give below represents a very accurate and well-made steel tape measure, manufactured by George M. Eddy & Co., Brooklyn, New York.

On one side it is divided into metres and centimetres; on the other into English inches. Two lengths are manufactured, 1½ and 2 metres, at $1.50 and $2.00, sent by mail on receipt of price.

For employment in clinical measurements, life insurance examinations, etc., as well as for ordinary use, a more desirable form of measure could not be found.

How to Tie a Surgeon's Knot.

A surgeon writes to the *Lancet* the following minute directions on this point:—

Having placed your ligature under and across the artery, take a free end in each hand; keep the end in the right hand in front of the end in the left hand in crossing the string, so as to make it pass across, around and up under the end in the left hand; it will still be in front of the other free end, although it has changed hands: keep it in front in again bringing it

across, and complete the knot in the usual way; the result will be a reef knot. If instead you pass the right hand end (which, after passing across, around, and up under the end in the left hand, is transferred as before to the left hand, and is still in front) behind the end that was in the left hand (but in making the knot has passed to the right hand), in completing the knot you will make a granny. Again, take an end in each hand, the end in the right hand being behind; keep it behind, and pass it, as before, across, around, and up under the end in the left hand; it will come up behind; still keep it behind, and on completing the knot a reef knot will be the result. If instead, before completing the knot, you allow it to pass in front of the other end, so altering its position with regard to its exit from around and under the other end, you will form a granny. In either case the knot is begun differently, and may be completed in two ways, a right and a wrong. The rule, simply put, is: keep the end that comes up under (from around the other in tying the knot) always the same side. If it comes up in front of the other end, keep it in front of the other end in completing the knot. If it comes up behind, keep it behind, and you cannot help making a reef knot; all that remains is to pull it tight.

On Hydrophobia.

Dr. M. Charteris, of Glasgow, in reporting some cases of hydrophobia to the *Lancet*, remarks:—

"In presence of a malady which constantly terminates in death," says Trousseau, "the practitioner's duty consists in boldly trying everything." To my mind the only hope in hydrophobia would be, at an early stage, bleeding to syncope, and having blood transfused from a healthy human subject in proportion to the quantity lost. I would not hesitate to adopt the treatment if I should be so unfortunate as again to be called to see a case of hydrophobia.

New Anæsthetic Agent.

Rabuteau, in a memoir read before the Académie des Sciences, states that he has investigated the physiological properties and mode of elimination of hydrobromic ether. He has satisfied himself that this anæsthetic agent, which possesses properties intermediate to those of chloroform, bromoform, and ether, might be advantageously employed to produce surgical anæsthesia. The hydrobromic ether is neither a caustic nor an irritant. It can be ingested without difficulty; and applied without danger, not only to the skin, but to the external auditory meatus and to the mucous membrane. It is eliminated completely, or almost completely, by the respiratory passages, in whatever way it may have been introduced into the system.

Balsam of Peru in Pulmonary Catarrh.

Before the Medical Society of Berlin, lately, Dr. Wiss called attention to the fact that years ago balsam of Peru was recommended by Marcus in internal diseases, especially in chronic pulmonary catarrh. In two well marked cases of this affection, of several years' standing, in old women, where auscultation and percussion showed the lung-tissue to be perfectly sound, and there was abundant puriform yellow expectoration, he succeeded in effecting a cure by the use of an emulsion of balsam of Peru in yolk of egg (4 parts in 120: dose, one tablespoonful every two hours). In one case recovery took place in eleven days, and in the other in three weeks; there was no return of the malady. He had previously given emetics and copaiba in these cases: under the use of the latter remedy, the quality of the expectoration had been improved, but its quantity had not been reduced.

Treatment of a Form of Deafness.

In cases of deafness from obstruction of the Eustachian tube, the quantity of gas contained in the drum of the ear diminishes. This diminution, generally attributed to absorption, appears rather to be due to diffusion by exchange with the gases of the blood. This fact has suggested to Dr. Loewenburg two new plans for preventing, or at least retarding the diminution of the air:—1. To insufflate air which has been alternately inspired and expired four or five times: this air, according to all foreknowledge, would remain inert in the presence of the gases of the blood. 2. Insufflation of hydrogen, a gas which resists the respiratory exchange of the lungs.

—The Committee appointed by the American Medical Association to urge upon Congress the printing of the "Subject Catalogue" of the National Medical Library, has presented an earnest memorial to that effect.

CORRESPONDENCE.

The Muriated Tincture of Iron a "Specific" for Erysipelas.

ED. MED. AND SURG. REPORTER:—

Since 1855 I have been a subscriber to and a constant reader of some of the leading medical journals of the country, and have often wondered how it was that no one of our scientific men who constantly write our medical literature has ever enunciated the statement which heads this article.

In 1853, in the Baltimore City Almshouse, Hospital, Dr. Francis Donaldson taught me to treat erysipelas with fifteen-drop doses of tinct. ferri. chloridi, every four hours; and anointing the affected part with ung. hyd., one part, and glycerine, two parts, and to use nothing else, unless, as required, a mild purgative.

Regarding erysipelas as a constitutional and not a local disease, that it is the result of a blood poisoning, I have long since treated the disease, whether infantile or adult, idiopathic or traumatic, erratic, phlegmonous or gangrenous, with the tincture of iron, never using iodine, or the nitrate of silver, or any external application, to arrest its progress, and always with unvarying success. From 1853 to the Confederate war, during that war, in which I was a surgeon, and since that time, I have seen and treated hundreds of cases, and have yet to see or know one to die. This, I know, is strong language, but, nevertheless, true. I am, therefore, fully prepared to endorse most heartily all that is said in the January number of Braithwaite's *Retrospect*, just now out, pages 44–47, upon this subject, by Dr. Charles Bell, of Edinburg, Scotland. His plan, as also that by Dr. George W. Balfour, is to give thirty drops of the muriated tincture of iron, not the perchloride, every two hours, until the disease disappears.

The course I have pursued for the past fifteen years, is, with an adult, to commence with fifteen to thirty drops of the muriated tincture (I have never used the perchloride) every four hours, increasing the dose each time it is given by the addition of five drops, till the stomach rejects the medicine. Whenever this occurs, I decrease the dose to tolerance. I have, on one or two occasions, had the dose to reach two teaspoonfuls, and in one case I remember a tablespoonful. Beyond this I have never gone, nor do I think it would be necessary to do so; yet, should there be no yielding in the disease, and no vomiting, I would not hesitate. As soon as the system has become "saturated" with the medicine, the disease has invariably yielded and begun to recede. I give the medicine diluted with water, or sweetened water, enough not to injure the teeth. I sometimes apply a lotion, ferri sulph., ten grains, to aquæ, one ounce, by a cloth saturated with the solution, warm, to the affected part. This, with a mild aperient, when required, and sometimes quinine dissolved in the tincture, constitutes the whole treatment.

As stated already, for twenty years, in hundreds of cases, I have pursued and seen others pursue this course, and where followed, have never known it once to fail. I regard the tincture of iron (muriated) more of a "specific" for erysipelas, than I do quinine for "ague" or "chill." In my hands it has proved more certain. In the language of Dr. Bell, "the remedy must be given in full quantity and frequency which I have recommended, in order to produce its beneficial effect in the severer forms of the disease." THOS M. MATTHEWS, M. D.

Mt. Enterprise, Rusk Co., Texas, Feb. 5th, 1877.

The Diseases of Great Men.

ED. MED. AND SURG. REPORTER:—

Some of the most illustrious men and women have been the victims of maladies of the nervous system. In almost every treatise on epilepsy, Cæsar, Mahomet, Petrarch, Napoleon, and Byron, are mentioned as being subject to this disease. It has been supposed by some that "the thorn in the flesh" of Apostle Paul, was his liability to epileptic attacks. Henry the Fourth, of England, after some time of ill-health, "became subject to dreadful fits, which would cause him to fall down apparently dead." These were undoubtedly epileptic in character. On the 20th of March, 1413, while he was at church, he was seized with a fit, and soon expired, being at the time forty-seven years old. Charles the Second, of England, in the midst of a life of vicious indulgence, was attacked by apoplexy, and died, after a few days' illness, on the 6th of February, 1685, in the fifty-fifth year of his life. Leonard Euler, while playing with one of his grandchildren, at the tea table, was seized with an apoplectic fit, and died in a few hours, at the age of seventy-six. Among the apoplectics we have such notable characters as Dickens, Thackeray, and Napoleon I.

Sir Charles Bell died, June 12th, 1842, of angina pectoris. He awakened with a frightful spasm of angina, asked to be supported, and immediately expired.

History furnishes abundant evidence of the frequency of affections of the mind among the magnates. Bishop Warburton, John George Zimmerman, Dr. Johnson, James V, of Scotland, King Henry, of England, Queen Elizabeth, and Frederick II, of Prussia, were all the victims of melancholia; Queen Francisca, of Portugal, George the Third, of England, Tasso Pascal, Wm Collier, Cowper, Charles XII, and Dr Johnson, were subject to attacks of insanity. Victor Amadeus I, of Sardinia, was a victim of kleptomania. Of the three disputed discoverers of modern anæsthesia, Wells died of insanity, Morton from a stroke of apoplexy, while Jackson is hopelessly insane. Dr. Adam Clarke died of cholera; Oliver Cromwell, of ague; Robert Duke, of starvation; Sir Humphrey Davy, as a result of injuries to an elbow; Alex-

ander the Great, of malarial fever; Augustus II, of gangrene of an old wound; Camillus, of the plague; Chaucer, of old age; Queen Mary, of small pox; John Racine, of abscess of the liver; Dr. William Hunter was subject to gout, but during one of these attacks he was paralyzed and shortly died; Napoleon III died of embolism; Prince William, of England, and Shelly were drowned; Thomas Chatterton and wife of Shelly committed suicide; Lord Byron fell a victim of remittent fever; John Keats, Edward VI, and Lænnec, were destroyed by phthisis pulmonalis.

Prof. Dunglison perished from disease of the heart. John Locke was a sufferer with asthma. Burns shortened his days by his excesses; Southey was demented; Jeremy Taylor died of some fever; John Bunyan died in 1688, in London, it is said, in consequence of a cold caught in a journey undertaken by him in inclement weather, with the object of reconciling a father and a son. Thomas Otnay perhaps choked. "His death has been frequently cited as a striking instance of the miseries of a literary career. It is related that, when almost starving, the poet received a guinea from a friend, on which he rushed off to a baker shop, bought a roll, and was choked while ravenously swallowing the first mouthful." Louisa, daughter of George II, when Queen of Denmark, died of an operation for hernia, at the early age of twenty-six. Queen Caroline, her mother, also died of hernia, after an operation by the celebrated Ranby; and Caroline, of Brunswick, wife of George IV, fell a victim to strangulated umbilical hernia. In regard to Washington, the weight of authority is in favor of the view that the cause of his death was œdema of the glottis rather than croup, as is so often stated.

Philadelphia. C. C. VANDERBECK, M. D.

Poisoning by Aniline Solution.

ED. MED. AND SURG. REPORTER:—

On January 20th I was hurriedly called to see Mrs. W. W., an old German lady, aged 64, who had taken about a teacupful of acetous solution of (Magendie's) aniline, by mistake for currant wine, about thirty hours previously. Living eight miles away, they did not send at once, but thought that she would get better.

She had intense burning pain at the stomach and in the head, after swallowing, and she "could not get her breath." She took salt-and-warm water, but did not vomit until eight hours afterward, when violent emesis and purgation set in, and continued until I saw her, when she vomited stringy mucus, mixed with blood; she was almost exhausted. Her extremities were icy cold, and the head cold and clammy; intense pain, on pressure over the stomach, which was hard and enlarged; tongue pallid in centre, and very smooth and red at the tips and edges; eyes injected, lower lids puffed; complained of burning pain in the eyes; and, "Oh, my head will burst;" hard pulse, 84; temperature 98¼°; respiration labored, 44.

Began treatment by giving five minims Magendie's solution of morphia hypodermically, over epigastrium; in thirty minutes, ten minims on tongue; vomiting and diarrhœa stopped; heat and friction to extremities; five grains bismuthi subnitratis, with one-fourth of a grain of morphia, every two hours; also, ten drops tincture digitalis and five drops muriated tincture of iron, in sweetened water. Milk, with a little brandy; frequently, small quantities of ice to allay thirst; no water.

January 21st, 3 P. M. Pulse compressible, 96; temperature 99°; respiration 44; extremities warm; face pale, moist; eyelids purplish, œdematous; tongue coated with thick, white fur; pain less in the head and eyes; epigastrium hard, tense, painful; abdomen tympanitic; cannot drink water, because of pain; passed a little reddish urine. Stop bismuth; continue tincture digitalis and iron, milk and brandy, broth, barley-water; ten grains hydrargyri chloridi mitis, twenty grains bicarbonate of soda, to move the bowels.

January 22d, 4 P. M. Pulse and temperature 100; respiration 36; pallor of countenance increased; more pain in abdomen; no stool yet; extremities warm; give the following powder at bedtime and another at daylight:—

R.	Leptandrin,	gr.j
	Podophyllin,	gr.⅛
	Ipecac.,	gr.½. M.

One-fourth grain morphia at bedtime, and hop poultices over abdomen; continue treatment.

January 23d, 11 A. M. Had several copious stools. Feels better. Calls for food.

January 24th. Doing well; able to be up. Continually improved until February 3d, when she had completely recovered.

This is the second case that I have seen, of aniline poisoning. To what are these violent symptoms due? They undoubtedly point to arsenic, which I discovered with the few means at hand. The treatment was only expectant; I could meet symptoms only. Thirty hours afterward there can be no more poison in the stomach when there has been violent emesis and catharsis for twenty-two hours. If any of your readers have any cases to report, or any suggestions to make in the treatment, I should like to hear. HENRY P. WENZEL, M. D.

Theresa, Wis.

Mechanical Dysmenorrhœa and Sterility.

ED. MED. AND SURG. REPORTER:—

The saying is trite, that "doctors will differ," and when I shall have related a case or two from my own experience, it will hardly be thought strange that I should differ from Dr. Lombe Atthill in the position he took on the subject of dysmenorrhœa and sterility, in an address before the British Medical Association.

Madam I. B. G., aged about 30 years, had been a great sufferer from dysmenorrhœa ever since the inception of menstruation. The pent-up discharges not only gave her great pain,

but were so long escaping through the narrow canal of the cervix uteri that they became decomposed, and being absorbed into the circulation, so contaminated the blood that she was sorely afflicted with phlegmonous ulceration, disordered liver and kidneys, dyspepsia, etc.; in fact, her whole health was undermined and broken down; and as she had been long under treatment of various physicians, who had perhaps tried almost everything except mechanical means, without relief, she had well-nigh despaired of recovery, and life had become almost a burden.

On the first interview, I frankly told her what my views were—that if she were to swallow all the medicine in the world, she could never be well without mechanical dilatation of the canal of the cervix uteri, to which she readily submitted, as the dernier resort. And I soon succeeded, by means of carbolized sponge tents, in effecting the dilatation necessary for free and easy menstruation, and with the aid of alterative tonics, she was soon restored to perfect health. As her husband died soon after her recovery, the question of her sterility remains open.

Madam P. L., aged about 30 years, would scarcely get through with one catamenial discharge before another menstrual period would arrive, with its train of agonies. She came under my treatment about two years and a half ago, when, upon first examination with speculum, I saw the long-retained menstrua, black as ink and thick as molasses, slowly oozing out through the os tincæ, about the size of a large pin, while she was merely semi-conscious, from severe suffering and prostration; she was literally in extremis. But by perseverance I succeeded, eventually, in dilating the canal of her cervix uteri, so that she menstruated freely and with ease.

But this lady, as soon as I had enabled her, had to come in a hack, ten miles, to my office, for further treatment. And finally, I succeeded, to my great satisfaction, as well as hers, in introducing the tent through the entire length of the canal, and discharged her, with the hope expressed that she would not only have the gratification of passing her monthly periods without pain, but be rejoiced with an offspring. But unluckily, in returning home over a rough road, the womb was capsized backward, and she, not knowing what had happened, suspected that I had maltreated her, and refused to have me called. But after she had suffered from the retroversion several days, in despair, I chanced to hear of it; and at once suspecting, from the account of the symptoms given, what was the matter, I voluntarily went and explained to her the nature of the case, and told her that it was an accident that might befall any lady at any time, and I proceeded, with reluctance on her part, to adjust the uterus, without any difficulty, and told her that it might possibly retrovert again, but that it was an easy matter to rectify it and relieve her permanently. But I believe I failed to disabuse her mind of suspicion of malpractice, and thus lost the credit to which I was so justly entitled, for curing so desperate a case. But since that time she has had two children. Now, if there be any other means of remedying such cases, I would be glad to know how to do it.

D. W. Foster, M. D.

Ville Platte, La., January, 23, 1877.

News and Miscellany.

Society Elections.

At the annual meeting of the American Microscopical Society of the City of New York, held Tuesday evening, January 9th, 1877, the following officers were elected for the ensuing year:—**President*, John B. Rich, M. D., 1 West 38th street, New York; **Vice-President*, William H. Atkinson, M. D., 41 East 9th street, New York; *Secretary*, O. G. Mason, Bellevue Hospital, New York; **Treasurer*, T. D'Orémieulx, 7 Winthrop Place, New York; *Curator*, John Frey, Bellevue Hospital, New York.

O. G. Mason, *Secretary.*

* Re-elected.

Prominent Surgical Operations.

In a review of surgery, for 1876, the *Medical Press and Circular* remarks that the history of last year has been more remarkable for uncommon and successful operations, or the successful adoption of new methods of treatment, than for any original practice or discovery. But the successful performance of abdominal section in a case of extra-uterine fœtation, with the preservation of both mother and child; the bold and successful extirpation of the spleen in two cases; the successful ligature of both external iliac arteries for double inguinal aneurisms; the very satisfactory employment in many cases of Esmarch's bandage in the treatment of popliteal aneurism; and the good results of using carbolized catgut in the ligature of arteries in the treatment of aneurism; these, and several other events which we cannot now call to mind, are enough to show that surgery has kept pace with the progress of other departments of the healing art.

Variations in the Use of Medicines.

Some interesting statistics are given in the *Archives Generales*, on the amount of some new remedies supplied by the medical men of the Assistance Publique. In 1869 the Central Pharmacy distributed 141 kilogrammes of chloroform against 308 kilogrammes in 1875. Chloral showed a still more rapid increase. In 1869 only 5 kilogrammes were required; while in 1875 360½ were consumed. Iodoform, from 250 grammes in 1859, rose to 28 kilogrammes in 1875; bromide of potassium rose from about 3 kilogrammes in 1855, to nearly 800 kilogrammes

in 1875; opium showed but small variations, but the same cannot be said of morphia, no doubt from the general use of hypodermic injections, for, from 275 grammes, in 1875 the amount rose to the enormous quantity of more than 10,000 kilogrammes. A very large augmentation in medicinal substances was also seen in the alcohol used in the hospitals and infirmaries of Paris. Thus, in 1855 the Assistance Publique only appropriated 1270 litres of alcohol to the use of the sick, while, in 1875 37,578 litres were used. The same increase is noticeable in rum and red wine. The use of white wine was sensibly diminished. The use of leeches has gone nearly out of fashion. In 1834 and the following years, up to 1837, the number of leeches employed exceeded a million; in 1874 the number had fallen to 49,000 only. The consumption of sulphate of quinine is on the increase, and represents 53,734 grammes in 1875, against 24,525 in 1855.

Removal.

Messrs. Snowden Brothers, the long established firm of manufacturers and importers of surgical instruments, have removed from Eighth street, to new and commodious quarters at No. 7. South Eleventh street.

Items.

—The latest remarkable industry is reported from Indiana, namely: hog resurrecting. The hog resurrectionists scour the country to find the bodies of porkers that died of cholera, which are made into soap. A petition to the Legislature recites these facts, and asks the prohibition of the business, on the ground that it is liable to scatter and extend the disease, and that the soap made from such diseased meat is unfit for use.

—It is stated that a large amount of ether drinking goes on in certain parts of the North of England. It is found that a man can get drunk at a much less outlay of money, on sulphuric ether than on alcoholic liquids; hence the consumption of the former drug is continually increasing.

—The scheme for creating a State board of examiners in Missouri has received the support of the State Medical Association, the St. Louis Medical Society, and also of a large number of the most influential members of the profession in the State. We doubt if it will work.

—After a study by Dr. E. McClellan, U. S. A., of the recent yellow fever epidemic in Savannah, he shows, by careful calculations, that the pecuniary loss to the city of Savannah and the State of Georgia, by the epidemic, was not less than $5,609,857.

Personal.

—Dr. M. M. Wishard, superintendent of the Orphans' Home at Knightstown, Indiana, committed suicide on the 14th instant, by cutting his throat.

QUERIES AND REPLIES.

Impotence.

Dr. A. J. Jessup, New York, replies to *Hallerus*, to employ general hygienic treatment. Five-grain doses of bromide of iron formed into a pill with extract of gentian, four times a day. Then, should there be considerable irritability, give twenty grains of bromide of potassium, in solution, at bedtime, each night. Enjoin abstinence from conjugal contact for a number of weeks.

Another.—Dr. C. B., of Miss., replies: I would suggest the following treatment. I will preface it by saying that I have found the phosphide of zinc the most suitable and reliable form of administering that important element, phosphorus. I have recently (and successfully) used, in two such cases as described by your enquirer, the following:—

R. Zinci phosphidi,	gr. ix
Extracti nucis vomicæ,	gr. xxss
Extracti conii,	drachm iss
Ferri redacti,	drachm iij
Vel. ferri phosphatis,	drachm vj. M.

Ft. pill No. 90.

Sig.—Take one pill three times a day.

At the same time, as adjuvants to this medication, apply galvanism to the lumbar region, and electricity to the prostatic portion of the urethra, by means of a urethral electrode, the negative pole being over the sacral plexus; also cold baths to the spine twice a day, and monobromide of camphor at night, in sufficient doses to control sexual excitement, taken half an hour before retiring.

Abortion.

Will the injection of warm or cold water within the uterus and outside of unbroken membranes cause abortion? J. B. W.

Indiana.

Reply.—We presume there can be no doubt at all but that it can and will. We are surprised to learn that it has been doubted.

MARRIAGES.

COOPER—SERVICE.—At the residence of the bride's parents, on the 14th instant, by Rev. A. McElwain, Dr. E. F. J. Cooper, and Miss Annie E., daughter of L. M. Service, M. D., all of Philadelphia.

EISENBREY—BRADLEY.—Thursday, February 8th, 1877, at St. Peter's Protestant Episcopal Church, Germantown, by the Rev. Dr. Rumney, Dr. J. Lehman Eisenbrey, of Philadelphia, and Miss Mary A. Bradley, daughter of J. W. Bradley, of Germantown.

DEATHS.

ADAMS.—In Stockbridge, Mass., on the 10th inst., Eliza Prentice, wife of Dr. L. S. Adams, aged sixty years.

BIGGAM.—Suddenly, at Carlstadt, N. J., Saturday, February 3d, Henry H. Biggam, M. D., in the twenty-sixth year of his age.

BUTLER.—On Sunday, February 4th, Lawrence D. Butler, only child of Dr. George H. and Henrietta L. Butler, aged two years.

CATTELL.—On the 12th instant, at Deerfield, New Jersey, Dr. Samuel G. Cattell, in the forty-sixth year of his age.

JAUDON.—At Philadelphia, on the 9th instant, Mary, wife of Dr. Chas. B. Jaudon, and daughter of the late Commodore Bainbridge, United States Navy.